

simona@idhw.state.id.us

**Division of Medicaid** Reimbursement Unit P.O. Box 83720 Boise, ID 83720-0036

PHONE: 208-364-1994 FAX: 208-334-2465

Note: The value of	of the unused medication	returned from ea	cn prescription	on must equa	ai \$15.00 or	more.	T					
* Provider Name:					#:		* Month:					
* Employee Name:  * Idaho Participant Medicaid ID # (MID)  * NDC #  * RX #  * Dispensing Date				* Phone #:			* Date Submitted:					
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\* Required Information

DHW Rev. Date: 7/1/04 **Provider Name** Page \_\_\_\_\_ of \_\_\_\_

* Idaho Participant Medicaid ID # (MID)	* NDC #	* RX #	* Dispensing Date	* Billing Date	* Original Quantity	* New Quantity	Original Amount Paid	New Amount Paid	Paid Difference	√ IF FEE IS PAID
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Returned Drug Fee Request Form

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